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ABSTRACT

The role and contribution to education of physical therapists are discussed. The history of physical therapy within the public schools extends beyond the implementation of special education legislation, but the law did promote a change from the medical to a more educational focus for therapy. Guidelines are summarized on the types of physical therapy available in the schools, including screening, evaluation, treatment, and consultation. Implications of the educational model for evaluation (specifically the therapist's contributions to the individualized education program) and intervention are noted. The role of therapists in consulting with teachers, other staff, and parents is emphasized. The therapist's ability to advise others on adaptive equipment is also stressed. (CL)

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School Physical Therapy: How Does it Relate to Education?

Irene R. McEwen

65th Annual Convention
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The question, "How does school physical therapy really relate to education?" is being asked increasingly as administrators look for ways to trim costs, as therapists are harder to lure from higher paying jobs, and as school districts everywhere attempt to improve their educuational programs and make them more effecitve and efficient.

I imagine most of you have heard or said things like school PT relates to education because PTs work on head control and so and so needs head control to be able to see the blackboard, or working on Susie's equilibrium reactions in standing will lead to walking so she can be more independent in school. These sorts of vague and futuristic examples are probably true, but I think that school PT can have a far greater and more direct impact on students' educational programs than is implied by examples like these.

For some students school PT will make the difference of whether or not they are able to be maintained in the least restrictive environment - or even get to it. For others PT can make the difference in whether or not they can actually achieve their educational goals, and for very young students, cognitive,

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social, communicative and other interrelated areas of development are closely tied to motor development and mobility, which a therapist is uniquely capable of facilitating.

I'm going to be talking much more specifically about ways that physical therapy can relate to education when I compare the medical and educational models of service delivery a bit later on, but first I'm going to give some background about why PTs are in schools, about what they do in a general sort of way, and then will give some of the reasons school PT may not always be as educationally relevant as it could be.

The first thing we'll look at is, why do we have physical therapists in the public schools?

A lot people think that physical therapists and handicapped students entered the public schools together in September, 1978 when PL94-142 was implemented. This was probably true in many places, but there were a number of school districts throughout the country had long traditions of providing education and physical therapy for physically handicapped children. Usually the students attended schools specifically for handicapped students, sometimes with names like hospital schools or cerebral palsy schools, and therapy was provided much it might have been in a hospital or clinic. Students received their treatments from their therapists and their education from their teachers, and the two rarely tried to coordinate what they were doing, except maybe to see that schedules didn't conflict. This is how

it was when I first started working in the public schools several years before 94-142 was implemented. I spent most of my time on the mats in the PT room and my students were brought to me by our aids who wore white uniforms. I did something to the kids, presumably something to make them better, and then sent them back to their classrooms.

Then PL94-142 was passed and implemented and all of that changed. Now there was a law that said related services, including PT, were to be provided when they were necessary for students to benefit from special education. All of a sudden the law said that therapy had to be related to education, rather than to medicine where it had been comfortably entrenched for a very long time.

This change from a medical to an educational focus hasn't been easy, not only for therapists, but also for parents, teachers, physicians and others involved with handicapped students.

The change has been difficult for therapists because most of us were trained to work in clincial settings, such as hospitals, rehab centers or private practice offices, where the emphasis is on helping patients achieve medical goals. PT training usually includes a few weeks in specialty areas such as geriatrics, orthopedics and pediatrics, but there is rarely much opportunity for students to pursue specialties, such as school therapy, until after graduation, when they are already working. And it is probably more difficult for school therapists to learn their

specialty than it is for other therapists because school therapy has been said to be farther removed from the traditional role of physical therapy than any specialty within the profession.

Therapists' training is not the only thing though that often causes therapy to be more medically than educationally focused. Parents, teachers, physicians and administrators often have expectations that reflect a medical model, because their notion of what therapists do is usually also based on the traditional medical model. Teachers often like and expect students to be taken out of the class for therapy so they have more time to work with other students, parents often lobby for more 1:1 treatment, thinking that if their children just got enough the problems might go away and in states where therapists need physicans' prescriptions, they are often medically oriented because that is how physicans were trained too.

I think that you can see how therapists' training and experiences and the expectations of other has made it something of a struggle to develop therapy services that are truly and directly related to students' educational goals. Gradually though, the role of therapists in the public schools is being redefined and clarified, and a new and unique professional identity is being developed.

So, what is this new role for PTs and what do they do in schools that's different from what they do in clinical settings? We'll start to answer this question by going over the American Physical Therapy Association's policies and guidelines for

physical therapy practice in educational environments and then go on to be much more specific.

First, very generally, what do school physical therapists do? American Physical Therapy Association guidelines define the school therapist's role as being concerned with providing services that prevent or minimize disability, relieve pain, develop and improve sensory and motor function, control postural deviations, and establish and maintain maximum performance within the individual's capabilities.

There doesn't seem to be anything wrong with that, it's a nice vague definition that covers most everything a therapist would do in educational settings - and in most any other setting too.

The guidelines also state that services within the educational environment are directed toward the development and maintenance of the handicapped child's physical potential for independence in all education related activities.

This sounds somewhat more educationally related, but it still pretty vague and non-specific, and isn't very helpful to a therapist trying to decide what to do and how to do it.

The guidelines then go on to talk about the kinds of services that might be provided in schools. Again, they aren't too helpful, but they are useful to keep in mind when we talk a bit later on about the different types of educationally related services.

The types of physical therapy services that can be provided in

the schools include:

1. screening - screening can be done either individually or in groups to try to find previously undetected problems, or to decide if possible problems need more thorough evaluation. As a therapist I often screened students individually who teachers had questions about, but weren't ready to refer for a full evaluation, and sometimes screened classrooms of students in a mildly handicapped program for gross motor problems. Therapists may also be involved in other group screenings, such as of kindergarteners or for scoliosis, but these are often done by classroom and PE teachers, school nurses or other school personnel.

2. evaluation - which is a more thorough individual assessment to determine what a student's problems problems might be and to determine appropriate intervention. As we'll talk about in a few minutes, the focus of the evaluation and the questions that are asked greatly effect whether or not school therapy is educationally related or not.

3. treatment - which is what many people think of as the primary responsibility of school therapist. As we'll see, it can be important, but may not always be the most effective or relevant service.

4. program planning - which means working with a student's whole educational team to develop educational goals and methods for achieving them.

5. consultation - which we are also going to be talking more

about later. Consultation can be with teachers, other school personnel, including related services personnel, parents, physicians, community resources, administrators and all of the others involved in the student's current and future educational environments.

6. administration - which includes all of those things necessary to plan, implement, coordinate and evaluate therapy services.

7. education - of school professionals and paraprofessionals, parents, physicians, administrators and any others whose knowledge about the student's physical status and needs can influence the educational program that is provided.

So, there's another list of things a therapist can do, but how can these services be provided?

As I've talked about before, they can be provided under a medical model, which not surprisingly leads to services that are medically related, or under an educational model, which can lead to educationally related services. We're now going to spend some time looking at elements both models and comparing them, which I hope will help to define educationally related services and how they can be achieved.

The most obvious sign of a medical model at work is that students are called "patients" or "clients" by the therapist. It's hard to imagine that therapy could be very educationally relevant for a "patient". Of course, school therapists call

their students "students" or "kids" (or maybe something more descriptive!) just as other school personnel do.

Another feature of a medical model is that students are evaluated away from the contexts of their everyday environments. This usually means that the therapist takes the student to a PT room or to another spot away from the classroom or other school activity areas and evaluates the student there. This could be in a therapy room, on the stage, in the bookroom or in the nurses office, but, wherever it is, it is away from the student's natural environment.

The form of the evaluation will vary depending of the student's disability, but it will probably focus on the child's basic physical functioning and status. For example, if the child has cerebral palsy the evaluation would probably focus on such things as muscle tone, reflexes and automatic reactions, gross motor developmental levels, range of motion, and perhaps some specific skills, such as transfers to a mat table and wheelchair pushing. Other students might get a manual muscle test, gait evaluation or assessment of orthotic devices. So far I've only mentioned things that are traditionally evaluated by PTs, but there are a lot often done by OTs that could also be included, such as evaluation of fine motor developmental level, sensory motor skills, dressing, eating and upper extremity orthoses. Again, in the medical model most, if not all of these things, would be assessessed in an isolated place, usually somewhere set aside for therapy.

If PT services are to be educationally relevant, it only makes sense for students to be evaluated in the settings in which their educational programs take place. With a newly referred student part of an initial evaluation may be very traditional, such as gathering medical information and reports about previous therapy programs. It may also be necessary to do a traditional PT assessment - looking at muscle tone, relflexes and developmental levels. But quickly the focus must move to how these things are affecting this particular student's educational program and this can only by done within the context of the student's real educational environments.

I think that the first step in nearly all evaluations has to be to talk to students' classroom teachers about how they see the students' disabilities are interfering with educational achievement and the contribution they think therapy might make. Obviously there can be a huge range of concerns, depending on such things as the student's age, disability, abilities and placement, and a similar range of hopes for therapy, some approriate, some not, some realistic and some not.

After learning what the concerns are, the next step is usually to observe the student in the classroom and other locations where problems have been identified or are likely. Evaluation in real environments almost always reveals problems that aren't detectable during an isolated evaluation in the PT room down the hall and the problems that are detected in real

school environments are those that are directly related to students' educational programs.

An example might be that an educational goal for a profoundly handicapped student is to "reach and grasp" - this is one that shows up all the time. Evaluation down the hall probably wouldn't show the need for the student to learn this activity and most certainly wouldn't show the need for the classroom staff to learn ways to facilite it throughout the school day. Another example might be a kindergartener who's having trouble sitting on the floor during show and tell or using the classroom bathroom. Another child may be working harder than necessary to write, or to access a computer.

Of course the classroom is not the only place students learn and have to function. Evaluation often also needs to take place in the lunchroom, the bathroom, the hall, PE, home ec, wood shop, the community and home - - and it requires input from anyone involved --parents, other related services personnel - and, quite often the student.

This type of evaluation (and intervention when we come to it) is very much in line with a recent position paper of the related services subcommittee of TASH (the Association for Persons with Severe Handicaps), which says related services personnel will:

1. Establish priorities with parents/advocates and other team members.
2. Observe and assess persons with handicaps in natural

settings.

3. Collaborate with family and team members to provide intervention strategies and adaptations that optimize participation in natural settings.
4. Teach specific and individualized procedures to enhance functional positioning, movement, and communication abilities in natural settings.
5. Evaluate the effectiveness of intervention procedures based on performance outcomes in natural settings.

One question an evaluation must answer is, "Are school therapy services, in any of it's guises, needed at all?" Not all physically handicapped students need therapy services because their handicaps may not be interfering with their educational programs, or therapy services may not be expected to change the situation. A fifteen year old with spastic diplegia may be doing fine in school, but not be able to keep up in the track unit of his PE class. There's not much I can do about that, or to change his "funny" gait. Another student in a classroom for multiply handicapped students may have a teacher who through the years has become expert in handling and positioning the student and facilitating movement during educational activities. So PT might just involve monitoring and consult as needed.

In the medical model two things seems to weigh the most heavily when looking at need for therapy - severity of handicap and age. With this model younger students rather automatically

receive more services than older students, who in some places may receive none, and more severely handicapped students are thought to need more therapy than students who are less severely handicapped. This seems to be a result therapists' training in developmental treatment, which focuses on normalizing development, so of course will have a greater impact on younger children and on the medical practice of providing the most intensive care to those who are the most dysfunctional.

In the educational model, students needs for therapy are evaluated according to their own individual, changing needs, not according to some predetermined age or severity citeria. Even though a fourteen year old may be said to have plateaued or reached his potential in developmental terms, he still may need to learn to get around in the community, sharpen a pencil in math class, reach the stove in home ec or open his locker in his new school.

It's usually a good idea to have a systematic way during an evaluation to decide whether or not a student needs therapy, which of course should reflect an educational need. A lot of school districts have developed guidelines, and many of them are based at least partially on a tool that I have worked with called Pediatric Screening: A Tool for Occupational and Physical Therapists - which is listed in the references and resources part of the handout. Although I think the tool could use some more work to make more specifically relate to need for school therapy (I especially don't like automatically giving more points

to younger children!) it does help therapists to look at the same things every time and to ask those important questions about the need for therapy as it relates to education.

Once the student has been evaluated a report is usually written, which under a medical model will be written in PT - ese, with a lot of talk about things like equilibrium reactions, trunk rotation, primitive reflexes and range of motion. An educationally related report, in contrast, will be understandable and meaningful to teachers and parents, will directly address their concerns and the student's educational needs, and will provide a basis for determining if therapy related goals are being achieved.

After the student has been evaluated its time to think about goals and objectives. With a medical model, goals and objectives often emphasize development of underlying physical potential, rather than specific functional skills. The intent here is to solve the basic problem so the patient will have the prerequisite skills that will allow functional skills to develop spontaneously. The sorts of things I'm talking about are like those that might be mentioned in an evaluation report, such as improving muscle tone, equilibrium reactions, head control and range of motion. When these goals and objectives are turned into part of an IEP, they are usually written separately from the rest of the IEP, often tacked onto the end and called something like a related services IEP or a therapy addendum.

Using an educational model, things are a little different.

Goals and objectives are directly related to students' educational programs, are functional, are written in educational terms and are integrated into students' overall IEPs.

This all sounds very reasonable, but it's often very difficult to translate traditional PT terminology, goals, objectives and practices into educational ones. I'm going to show some examples of how to do this, but first will go over some questions that are important to ask when determining overall goals and objectives, which, of course, those to do with PT are a part.

Most often we are dealing with students who have a lot of needs and because we can't do everything, we have to decide what to do that will make the most positive difference for the student. Some questions that can help to identify these things are :

1. What are the needs and immediate concerns of the student's teachers and parents? What can help to make the student easier to live with? What are the student's concerns?

2. How functional is the proposed objective? Is it in itself a useful activity, that provides natural reinforcers, and can it be expected to facilitate further learning? For example grasping a spoon can be far more useful and naturally reinforcing than grasping a peg, and transferring to a toilet far more useful than transferring to a mat table.

3. Realistically, is there time to achieve a proposed objective? Are there other functional, significant objectives that are more likely to be achievable? Sometimes when working

in a very developmental type of way, I have felt like none of us will live long enough to get the student far enough along on the developmental scale to make much difference. Are there other skills, even splinter skills, that might be more achievable and make more difference?

4. How often are the skills needed in the student's environment? Will the home and school environment help maintain the skill? Are the skills likely to be needed in the future? Are they appropriate for any age person or will they have to be replaced later? Are they an unnecessary prerequesite to a higher level skill?

So, with some of that in mind, and the need for objectives to be educationally relevent, functional, and written in educational terms we'll look at some examples. (Overhead)

On to treatment. In the medical model, goals and objectives nearly always require the direct 1:1 intervention by a therapist, or perhaps a therapy assistant, and treatment is usually in isolated settings, emphasizing development of basic developmental motor skills like head control, propping on elbows, rolling, crawling, sitting and so forth. This is especially true for students who have cerebral palsy.

In the educational model, direct 1:1 therapy is only one of a range of direct and indirect services may be provided to meet the student's educational goals and objectives. If direct treatment is needed it usually focuses on functional skills in natural educational environments.

At this point that is probably the only thing that makes sense, but therapy in everyday settings is often the most identifiable and meaningful sign of therapy that is truly integrated into an educational program. Very rarely there are times when 1:1 training in isolated settings is needed to develop specific skills, but these instances should be few and short term.

The specific location of direct therapy, or, more likely, the several locations, will vary with the student's needs and the type of educational program. For example, it is usually very appropriate to work on basic developmental motor skills in a preschool classroom or early elementary special education classroom. Students at this age level can usually benefit from developmental therapy and motor development is an integral part of most early childhood programs. Basic skills can often be developed during actual classroom activities, rather than by using large balls and bolsters, which we don't see real often in real life. For example, sitting balance can be facilitated and practiced while a student is involved in a table or floor activity, head control can be facilitated during a movie or show and tell time, or standing balance can be facilitated and developed while painting at an easel. There are usually hundreds of opportunities every day to help these young students improve their basic developmental status in functional ways, and providing therapy in the classroom not only lets the therapist take advantage of some of them, but can teach the classroom staff

how to take advantage of others.

It's often the most difficult to integrate 1:1 therapy into the classroom of young students who might still benefit from basic developmental therapy, but are in regular first or second grade classes. It's usually inappropriate to do much handling in the classroom, but it often very appropriate and necessary to work both in the classroom and other locations to develop specific functional skills.

Beyond the second grade or so, basic developmental therapy is usually not likely to provide much more, and emphasis should be on training specific skills where ever they are needed - throughout the school and the community. Direct therapy is often needed in the inital stages of skill development to work out how something will be done and to gain initial skills, and then further development is often best supervised by classroom staff and others who interact with the student on a regular basis. For example a PT may work directly with a student to discover optimal positioning and facitation techniques to enable the student to point to selections on a communication board. Once these have been worked out, in conjuction with the speech clinican and teacher, further practice is turned over to them, with the PT coming in as necessary when things go wrong. Other examples are when a PT works out ways a student can transfer with the aid of only one person, or finds feeding techniques that work for a particular student or helps a student learn to open and close doors from a wheelchair. Once the

student becomes proficient enough and the technique appears to be working, it is usually time to turn the rest of the training over to someone else, especially when therapist's time is very limited.

This leads into the next comparison between the medical and educational models - the types of services provided.

In the medical model direct, 1:1 therapy is used most often to cure the patient and send him on his way. This rarely happens in schools. As we've mentioned already, some students will need direct therapy to develop skills necessary to achieve educational goals and this direct therapy can be provided individually or in groups. It's hard to think of an instance though where direct therapy is all that is needed. The indirect services are often the most significant and the most time consuming. Two of the most important indirect services are consulation and provision of equipment.

Consultation with a wide range of school personnel, parents, medical personnel and community resources may be necessary, but if physically handicapped students are to achieve educationally, consultation with teachers and parents is essential. Therapists usually work with students a couple of hours a week at the most, but classroom staff and parents are with them for hours every day. It's pretty obvious that intervention will be much more effective if these people learn how to handle the student in therapeutic ways, or facilitate more normal movement, or seat the student well in a wheelchair, or encourage independent

mobility, or feed him therapeutically, or any of dozens of other everyday activities and needs that can be done in ways that will help students achieve those goals faster and more functionally.

This sounds reasonable but it's often hard to do, mainly I think because therapists usually are not trained to be educational consultants and teachers are not trained to use therapists as consultants. The reverse is also true, teachers weren't trained to be consultants to therapists and therapists usually don't know how to use teachers as consultants. I'll say "teachers" just to keep things simple, but most of what I'll be talking about also applies to other related services personnel, such as OTs and speech pathologists, and it often applies to parents.

I think that if students are evaluated within the context of the educational setting, with input from parents and school personnel, and educational goals and objectives are mutually determined, what the therapist needs to do and what the teacher needs to do should be more obvious.

I'm going to talk now about some of those things that therapists and teachers can do to make a consulting more effective - and more meaningful to students.

Therapists need to delegate and train those tasks that can be appropriately and more effectively carried out by others. We're often used to doing it all ourselves, and have to learn how to delegate and to teach other adults. This is very much in line with the transdisciplinary model of service delivery in which

professionals consult with other professionals, acquire some of the other person's knowledge and then incorporate that knowledge into their own practices. Teachers can acquire knowledge that is appropriately given by therapists and therapists can acquire a teacher's knowledge, then both can incorporate the other's knowledge into their own interactions with a student. For example, a teacher may learn how to position a student optimally in a wheelchair and facilitate hand function so the student can use a computer or can interact with objects. Of course it's essential that everyone interacting with students learn appropriate handling and facilitation techniques so they can be a part of the student's everyday life, not just something that's done during therapy time. On the other hand, there are dozens of ways a therapist can incorporate others' expertise. A couple of simple examples are having a student practice math and reading skills when going to a neighborhood shopping area to learn electric wheelchair skills or using methods to improve a student's communication board skills whenever the therapist interacts with the student.

That sounds fine, but it's usually not that easy, especially when a medical model is at work. In the medical model the therapist may be willing to relinquish some knowledge, but often puts it in the form of an order or prescription. "You will do such and such exercise so many times a day and position the student in these devices, changing positions every so many minutes. See you in two months." This may be an exaggeration,

but too often it's fairly close to the way things work. As I've said so many times before, in the educational model, goals and objectives and responsiblity for each part of the IEP are determined by the whole educational team. If the team has decided that these exercises are to be part of the educational program and that the therapist is responsible for teaching the teacher how to do them and the teacher is responsible for seeing that they are done, there shouldn't be any problems.

They both have some other responsiblities though that are often overlooked. It is essential that the therapist check back regularly to see if things are working and if changes need to be made, and to be sure that any suggestions are essential and fit into the student's total educational plan. Teachers must also take responsibility for seeing that the activities fit into the plan, and, if so, that they are carried out. It is usually a good idea if the teacher and therapist together work out data collection methods to document student participation in activities and to record progress. One responsiblity that teachers often don't feel comfortable about is telling the therapist loud and clear when something isn't working, if it isn't relevant or when other problems or needs come up. Most therapists aren't mind readers so if there are problems teachers need to say so - to the therapist, via carrier pidgeon if necessary.

When I was preparing this presentation I asked several people in special education how they thought physical therapy related to

education. Well, I got an earful and much of it had to do with how therapists function as consultants. I've already talked about many of the things they mentioned, but have sort of a grab bag left that I'd like to throw in here.

One person said that she thought it was important for therapists to be aware of and to dispel the myths that she has seen when working with severely and profoundly physically handicapped students. A common myth seems to be that profoundly physically handicapped students are too fragile for much handling, so they tend to receive far less than they need in everyday school activities. Another myth is that surgery or braces will take care of the problems, often without the need for follow-up therapeutic activities. Another myth is that wheelchairs are bad and that students are better off in various positions on the floor, some even saying students can breathe better when lying down. I've come to believe that there is more to life than looking at peoples ankles and that a properly fit wheelchair is usually the most therapeutic and functional positioning device there is.

A fourth myth is that physical activities belong to the therapist and "academic" things to the teacher, and that therapists are only trying to get the teachers to do their work when they consult rather than work directly with students. I think we've talked enough about the importance of establishing mutual goals and carrying over therapeutic activities throughout the day to take care of this myth, but it's good to be aware of

it, and to ensure that what teachers are asked to do is indeed fair and within their capablities.

I have talked mainly about consultation with teachers, but I think that much of it also relates to consultation with other school personnel and can also apply to consultation with parents. Another type of consultation that I think can be very different, but is very important is consultation with physicians. A school PT is often a most effective liason between the medical and educational worlds of physically handicapped students, and can act as a translator in both. Physicians often need to know such things as how students function in everyday settings, not just in the clinic, and maybe how a planned, but postponable, surgery might affect a student's education. Since physicians are usually the ones that order equipment, it is very important for a therapist to provide input about what is needed and to follow up once it's delivered to see that it's right. And very gently and diplomatically, some physicians need to learn that they are a part of a handicapped student's educational team, not the leader. In some places where therapists need physicians' orders, physicians have tried to dictate what type and how much therapy students will receive. Of course a physician's input is valuable and is often essential, but it is my belief and my understanding that their orders needn't rather automatically be followed, but will be considered along with the input of other members of the educational team. It can be a responsiblity of school therapists help physicians change their medical expectation of school

therapy.

The second important indirect service that school therapists provide, that I'm going to talk about, is adaptive equipment. Good adaptive equipment can make the difference between a student who can do something and one that can't and between facititating a student's physical potential and actually harming the student. There are as many types of adaptive equipment as there are students and much of it can have a very significant impact on students educational programs. For many students the most important piece of equipment is a wheelchair. The right wheelchairs do many things, such as help students to hold their heads up and use their hands, help prevent increasing deformity, sometimes make independent transfers possible, and provide that all important means of independent mobility.

Other positioning equipment can also be helpful, such as prone standers and floor sitters, and there is an endless array of devices to designed to overcome hand control problems such as adapted computer input devices, adaptive feeding equipment, adaptive typewriters, adapted crayons and scissors and communication device adaptations. Therapists often spend a lot of time and energy getting the right equipment for students, but like time spent training others, the effort can be far more worthwhile than many other things a therapist might do.

The final comparison between the medical and educational models is the size of the caseload or student load. In the medical model therapists usually have fairly low caseloads so

they can provide all of that intensive 1:1 therapy. They also usually have far fewer of the other responsiblities of a school therapist.

In the educational model student loads must be managable. It does no one any good when therapists are responsible for far too many students, which seems to be happening more and more frequently with the current shortage of therapists. Therapists first need objective ways to identify students who need school therapy. Then we need to manage our student loads in efficient and effective ways that provide reasonable services to as many students as possible. There may come a time however, when it is impossible to provide meaningful services, when it is necessary to say "no more". At that point I hope we can say it has become a school administrator's problem.

Some conclusions:

I think that school physical therapy can be a very valuable part in the educational programs of handicapped students, probably in an many ways as there are students. For very young children therapy can help help provide the basic movement and mobility that is essential for cognitive, social and communication development. Therapy can train functional skills needed to participate in and benefit from an educational program and can teach teachers and parents to provide more effective intervention. Provision of appropriate adaptive equipment can also make a significant impact on educational achievement.

A lot of things must happen for therapy services to be

educationally relevant, but three seem the most basic and the most critical.

First, therapists must reorient themselves to use of an educational model.

Second, teachers, parents, physicians and others must demand educationally related goals, objectives and services and resist demanding those that are medically oriented.

And finally, administrators must support a move from a medical model to an educational model, which might mean providing additional personnel or supporting a therapist who has decided 1:1 developmental therapy is no longer appropriate for a student.

A resource that I think might be very helpful to some school therapists are two correspondence courses given through the University of Washington. Washington State requires that therapists and other related services personnel be certified to work in the schools. These courses were developed as part of the training process for therapists working toward continuing level certification. The first course is a three credit course which gives describes the certification process, gives an overview of working in the schools and then, the major portion of the course, has a unit on the therapist's role in the management of students with cerebral palsy. The second course, for which the first is a prerequisite, has units on the therapists' role in the management of students with myelodysplasia, muscular dystrophy and developmental delay.

I'm excited about the courses because they strongly emphasize the educational relevance of therapy - which is what school therapy must be all about.

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